

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 22 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44236

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether years, months or days) 2
In this community

3. (a) PRINT FULL NAME

Mattie Hall

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex

Female

5. Color or race

Negro

6. (a) Single, widowed, married,

divorced married

6. (b) Name of husband or wife

unknown

6. (c) Age of husband or wife if

alive 4 years

7. Birth date of deceased

unknown

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

abt 83

hr.

min.

9. Birthplace

unknown

(City, town, or county)

(State or foreign country)

10. Usual occupation

housewife

11. Industry or business

12. Name

unknown

13. Birthplace

unknown

(City, town, or county)

(State or foreign country)

14. Maiden name

unknown

15. Birthplace

unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Charley England

(b) Address

St. Louis

17. (a)

Burial

(b) Date thereof

Jan 22 1941

(c) Place: burial or cremation

Harlem Cem

18. (a) Signature of funeral director

(b) Address

19. (a)

12-31-40

(Date received local registrar)

(b)

Ella Clayton

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Missouri

(b) County

Knight

(c) City or town

St. Louis

(If outside city or town limits, write "RURAL")

(d) Street No.

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month

Dec

day

31st

year

1940

hour

12:30

minute

a.m.

21. I hereby certify that I attended the deceased from

25th 1940 to Dec 31st 1940

that I last saw her alive on Dec 26th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death

Lobar Pneumonia

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work

(Specify type of place)

(e) Means of injury

23. Signature

W. Murrell

(M. D. or other)

Address

St. Louis

Date signed 1/21/41

RECEIVED

District Health Officer No. 0;

District File Number 141-81

Date Filed JAN 10 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44236

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 906

Primary Registration District No. 4547

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Wright
(b) City or town Wartville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT
FULL NAME Mattie Hall

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F 5. Color or race Black 6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if
alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) Feb 15 (b) Gella Clotton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____ (If outside city or town limits write "RURAL")

- (d) Street No. _____ (If rural, give location)

- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

- and that death occurred on the date and hour stated above.

- Immediate cause of death _____

- Due to _____

- Due to _____

- Other conditions _____
(Include pregnancy within 3 months of death)

- Major findings:
Of operations _____

- Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

- While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature N. A. Murrell (M. D. or other) _____

- Address Wartville Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

